Appendix 1
National HCFA 1500 Claim Form Sample
(Physical Therapy)

APPROVED OMB-0938-0008

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY SEX M ☒ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: WI

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX) XXX-XXXX

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-7

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B12345

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 435.9 3.
2. 437.0 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 03 95	06 08 95	7	1	97116	PT	1	XX XX	8.0				12345600
2 02 23 95		7	1	97110	PT	2	XX XX	1.0				12345600
3 02 01 95		7	1	97265	PT	1	XX XX	2.0				12345600
4												
5												
6												Recipient Spenddown

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $ XXX.XX

29. AMOUNT PAID $ XX.XX

30. BALANCE DUE $ XX.XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
I.M. Provider MM/DD/YY
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
I.M. Nursing Home
506 Willow
Anytown, WI 55555

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
I.M. Billing
1 W. Williams
Anytown, WI 55555 87654300
PIN# GRP#

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

Appendix 1a
National HCFA 1500 Claim Form Sample
(Rehabilitation Agency)

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) M | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY SEX M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: WI

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX) XXX-XXXX

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-7

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M | F

b. AUTO ACCIDENT? YES | NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B12345

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 435.9 3.

2. 437.0 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 03 95	06 08 95	7	1	97116	PT	1	XX XX	8.0				
2 02 23 95		7	1	97110	PT	2	XX XX	1.0				
3 02 01 95		7	1	97265	PT	1	XX XX	2.0				
4												
5												
6												Recipient Spenddown

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $ XXX.XX

29. AMOUNT PAID $ XX.XX

30. BALANCE DUE $ XX.XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Provider MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

I.M. Nursing Home
506 Willow
Anytown, WI 55555

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555 87654300

PIN# GRP#

PATIENT AND INSURED INFORMATION — CARRIER — PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

Appendix 1b
National HCFA 1500 Claim Form Completion Instructions for Physical Therapy Services and Rehabilitation Agencies

Use these claim form completion instructions to avoid denial or inaccurate claim payment. Enter all required data on the claim form in the appropriate element. Include attachments only when requested. All elements are required unless "not required" is specified.

Medicaid recipients receive an identification card when initially enrolled into Wisconsin Medicaid and at the beginning of each following month. Providers must always see this card before providing services. Please use the information exactly as it appears on the identification card to complete the patient and insured information.

Element 1 - Program Block/Claim Sort Indicator
Enter the claim sort indicator:

"T" - Physical Therapy Services.
"M" - Rehabilitation Agency.

Claims submitted without this indicator are denied.

Element 1a - Insured's I.D. Number
Enter the recipient's 10-digit identification number from the current identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim. In this case, the recipient's Medicare number may also be indicated.

Element 2 - Patient's Name
Enter the recipient's last name, first name, and middle initial from the current identification card.

Element 3 - Patient's Birth Date, Patient's Sex
Enter the recipient's birth date in MM/DD/YY format (i.e., February 3, 1955, would be 02/03/55) from the identification card. Specify if male or female with an "X."

Element 4 - Insured's Name (not required)

Element 5 - Patient's Address
Enter the complete address of the recipient's place of residence.

Element 6 - Patient Relationship to Insured (not required)

Element 7 - Insured's Address (not required)

Element 8 - Patient Status (not required)

Element 9 - Other Insured's Name
Bill health insurance (commercial insurance coverage) before billing Wisconsin Medicaid unless the service does not require health insurance billing according to Appendix 18a of Part A, the all-provider handbook.

✓ Leave this element blank when the provider has not billed the other health insurance because the "Other Coverage" of the recipient's identification card is blank, the service does not require health insurance billing according to Appendix 18a of Part A, the all-provider handbook, or the recipient's identification card indicates "DEN" only.

✓ When "Other Coverage" of the recipient's identification card indicates HPP, BLU, WPS, CHA, or OTH, and the service requires health insurance billing according to Appendix 18a of Part A, the all-provider handbook, one of the following codes MUST be indicated in the *first* box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part by the health insurance. The amount paid by the health insurance to the provider or the insured is indicated on the claim.
OI-D	DENIED by the health insurance company following submission of a correct and complete claim or payment was applied towards the coinsurance and deductible. Do NOT use this code unless the claim in question was actually billed to and denied by the health insurer.
OI-Y	YES, the card indicates other coverage but it was not billed for reasons including, but not limited to the following: ➔ Recipient denies coverage or will not cooperate. ➔ The provider knows the service in question is noncovered by the carrier. ➔ The health insurance failed to respond to initial and follow-up claim. ➔ Benefits not assignable or cannot get an assignment.

✓ When "Other Coverage" of the recipient's identification card indicates "HMO" or "HMP", indicate one of the following disclaimer codes, if applicable.

Code	Description
OI-P	PAID by HMO or HMP. The amount paid is entered on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Note: The provider may *not* use OI-H if the HMO or HMP denied payment because an otherwise covered service was not provided by a designated provider. Wisconsin Medicaid does not pay for services covered by an HMO or HMP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill Wisconsin Medicaid for services which are included in the capitation payment.

Element 10 - Is Patient's Condition Related to (not required)

Element 11 - Insured's Policy, Group, or FECA Number

Use the *first* box of this element for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed before billing Wisconsin Medicaid. When the recipient's identification card indicates Medicare coverage, but Medicare does not pay, indicate one of the following Medicare disclaimer codes. The description is not required.

Code	*Description*
M-1	Medicare benefits exhausted. This code applies when Medicare has denied the claim because the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted.

Use M-1 in these two instances only:

For Medicare Part A (all three criteria must be met):
- The provider is certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The procedure provided is covered by Medicare Part A but is denied due to benefits being exhausted.

For Medicare Part B (all three criteria must be met):
- The provider is certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The procedure provided is covered by Medicare Part B but is denied due to benefits being exhausted.

M-5 Provider not Medicare-certified. This code applies when the provider is not required by Wisconsin Medicaid to be Medicare Part A or Part B certified, has chosen not to be Medicare Part A or Part B certified or cannot be Medicare Part A or Part B certified.

Use M-5 in these two instances only:

For Medicare Part A (all three criteria must be met):
- The provider is not certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is covered by Medicare Part A.

For Medicare Part B (all three criteria must be met):
- The provider is not certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is covered by Medicare Part B.

M-6 Recipient not Medicare-eligible. This code applies when Medicare denied the claim because there is no record of the recipient's eligibility. Use M-6 in these two instances only:

For Medicare Part A (all three criteria must be met):
- The provider is certified for Medicare Part A.
- The service is covered by Medicare Part A.
- The recipient is not eligible for Medicare Part A.

For Medicare Part B (all three criteria must be met):
- The provider is certified for Medicare Part B.
- The service is covered by Medicare Part B.
- The recipient is not eligible for Medicare Part B.

M-7 Medicare disallowed or denied payment. This code applies when Medicare actually denies the claim for reasons given on the Medicare remittance advice. Use M-7 in these two instances only:

For Medicare Part A (all three criteria must be met):
- The provider is certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is covered by Medicare Part A, but is denied by Medicare Part A.

For Medicare Part B (all three criteria must be met):
- The provider is certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is covered by Medicare Part B, but is denied by Medicare.

M-8 Noncovered Medicare service. This code applies when Medicare was not billed because Medicare does not cover the service at this time. A list of services that are not covered under Medicare is in Appendix 16 of Part A, the all-provider handbook.

Nursing homes must use M-8 for Medicare-eligible recipients who are hospitalized and do not wish to return to a Medicare-covered bed.

For Medicare Part A (all three criteria must be met):
- The provider is certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is not covered under Medicare Part A.

For Medicare Part B (all three criteria must be met):
- The provider is certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is not covered under Medicare Part B.

Leave the element blank if Medicare is not billed because the recipient's Medicaid identification card indicated no Medicare coverage.

Leave the element blank if Medicare allows an amount on the recipient's claim. Attach the Explanation of Medicare Benefits (EOMB) to the claim. Do not enter Medicare paid amounts on the claim form. Refer to Appendix 17 of Part A, the all-provider handbook, for more information about the submission of claims for dual-entitlees.

Elements 12 and 13 - Authorized Person's Signature
(Not required since the provider automatically accepts assignment through Medicaid certification.)

Element 14 - Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 - If Patient Has Had Same or Similar Illness (not required)

Element 16 - Dates Patient Unable to Work in Current Occupation (not required)

Element 17 - Name of Referring Physician or Other Source
Enter the referring or prescribing physician's name.

Element 17a - I.D. Number of Referring Physician
Enter the referring provider's six-character UPIN number. If the UPIN number is not available, enter the Medicaid provider number or license number of the referring provider. Refer to Appendix 3 of Part A, the all-provider handbook, for the UPIN directory address.

Element 18 - Hospitalization Dates Related to Current Services (not required)

Element 19 - Reserved for Local Use
If an unlisted procedure code is billed, describe the procedure. If element 19 does not provide enough space for the procedure description, or if multiple unlisted procedure codes are being billed, attach documentation to the claim describing the procedure(s). In this instance, indicate "See Attachment" in element 19.

Element 20 - Outside Lab (not required)

Element 21 - Diagnosis or Nature of Illness or Injury
Enter *the International Classification of Disease* (ICD) diagnosis code for each symptom or condition related to the services provided. Manifestation ("M") codes are not acceptable. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis. The diagnosis description is not required.

Element 22 - Medicaid Resubmission (not required)

Element 23 - Prior Authorization

Enter the seven-digit prior authorization number from the approved prior authorization request form. Bill services authorized under multiple prior authorizations on separate claim forms with their respective prior authorization numbers.

Element 24a - Date(s) of Service

Enter the month, day, and year for each procedure using the following guidelines.

✓ When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.

✓ When billing for two, three, or four dates of service on the same line, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing *only* the date(s) of the month (e.g., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four dates of service per line if all of the following apply:

✓ All dates of service are in the same calendar month.
✓ All services are billed using the same procedure code and modifier, if applicable.
✓ All procedures have the same type of service code.
✓ All procedures have the same place of service code.
✓ All procedures were performed by the same provider.
✓ The same diagnosis is applicable for each procedure.
✓ The charge for each procedure is identical. (Enter the total charge *per detail line* in element 24f.)
✓ The number of services performed on each date of service is identical.
✓ All procedures have the same HealthCheck indicator.
✓ All procedures have the same emergency indicator.

Element 24b - Place of Service

Enter the appropriate *single-digit* place of service code for each service. Refer to Appendix 3 of this handbook for a list of allowable place of service codes for physical therapy services.

Element 24c - Type of Service Code

Enter the appropriate single-digit type of service code. Refer to Appendix 3 of this handbook for a list of allowable type of service codes for physical therapy services.

Element 24d - Procedures, Services, or Supplies

Enter the appropriate five-character procedure code and, if applicable, a maximum of two, two-character modifiers. Refer to Appendix 3 of this handbook for a list of allowable procedure codes for physical therapy services.

Element 24e - Diagnosis Code

When multiple procedures related to different diagnoses are submitted, use column E to relate the procedure performed (element 24d) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

Element 24f - Charges

Enter the total charge for each line.

Element 24g - Days or Units

Enter the total number of services billed for each line. Physical therapy services must be billed following the *Conversion of Therapy Treatment Time Guidelines* in Appendix 5 of this handbook.

Element 24h - EPSDT/Family Planning
Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. If HealthCheck does not apply, leave this element blank.

Element 24i - EMG
Enter an "E" for *each* procedure performed as an emergency, regardless of the place of service. If the service is not an emergency, leave this element blank.

Element 24j - COB (not required)

Element 24k - Reserved for Local Use
Enter the eight-digit provider number of the performing provider *for each procedure*, if it is different than the billing provider number indicated in element 33.

Note: Rehabilitation agencies do not indicate a performing provider number.

When applicable, enter the word "spenddown" and under it, enter the spenddown amount on the last detail line of element 24k directly above element 30. Refer to Section IX of Part A, the all-provider handbook, for information on recipient spenddown.

Any other information entered in this column may cause claim denial.

Element 25 - Federal Tax ID Number (not required)

Element 26 - Patient's Account No.
Optional - The provider may enter up to 12 characters of the patient's internal office account number. This number appears on the fiscal agent Remittance and Status Report.

Element 27 - Accept Assignment
(Not required, provider automatically accepts assignment through Medicaid certification.)

Element 28 - Total Charge
Enter the total charges for this claim.

Element 29 - Amount Paid
Enter the amount paid by the health insurance. If the other health insurance denied the claim, enter $0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

Element 30 - Balance Due
Enter the balance due as determined by subtracting the recipient spenddown amount in element 24k and the amount paid in element 29 from the amount in element 28.

Element 31 - Signature of Physician or Supplier
The provider or an authorized representative must sign in element 31. Also enter the month, day, and year the form is signed in MM/DD/YY format.

Note: This may be a computer-printed or typed name and date or a signature stamp with the date.

Element 32 - Name and Address of Facility Where Services Rendered
If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit provider number.

Element 33 - Physician's, Supplier's Billing Name, Address, Zip Code, and Telephone
Enter the billing provider's name (exactly as indicated on the provider's notification of certification letter) and address. At the bottom of element 33, enter the billing provider's eight-digit provider number.

Appendix 2
Electronic Media Claims (EMC) Screen

WELCOME TO ELECTRONIC CLAIMS SUBMISSION DATE 010193

EDS - WISCONSIN MEDICAID

BP NBR 33 L NAME 2 F NAME 2 MID 1A

PCN 26 OI 9 TPL 10 MSC 11 PA NBR 23

RP NBR 17 FP NBR 32 OP NBR

DIAG 1 21.1 2 21.2 3 21.3 4 21.4 5 21.5

DTL	FDOS	A1A2A3	POS	PROC	M1	M2	PP NBR	DX	CHARGE	UNIT	TOS	EMG	H/F
1	24.3	A	B	D	D	D	K	E	F	G	C	I	H
2													
3													
4													
5													
6													
7													
8													
9													
10													

TOT BILL 28 OI PAID 29 PAT PAID 24.K NET BILL 30

Doc #1 Page #1 Field #6 Form: MEDVENDR 01-01-1993 10:17:35

BENEFITS OF ELECTRONIC BILLING

One of the greatest benefits of electronic billing is that less information is required for processing. Less information means less room for error. The data elements that are not required on electronic claims include the following:

- ✓ Claim indicator.
- ✓ Patient's date of birth.
- ✓ Patient's address.
- ✓ Patient's sex.
- ✓ Signature of provider.
- ✓ Provider's name and address.

Other benefits of billing electronically include:

- ✓ Free software.
- ✓ Improved cash flow.
- ✓ Lower detail denial rate.
- ✓ Flexible submission methods.
- ✓ Claim entry controlled by provider.
- ✓ Online edits.

To request more information on electronic claims submission contact the Electronic Media Claims (EMC) Department at the address located in Section IV of this handbook.

Appendix 3
Wisconsin Medicaid
Place of Service (POS) and Type of Service (TOS) Codes for Physical Therapy Services, Rehabilitation Agencies, Independent Therapists, Therapy Clinics, and Therapy Groups*

Wisconsin Medicaid Allowable POS Codes	
POS Code	**Description**
0	Other
3	Office
4	Home
7	Nursing Home
8	Skilled Nursing Facility

Wisconsin Medicaid Allowable TOS Codes	
TOS Code	**Description**
1	Medical (Physical Therapy Services)
9	Rehabilitation Agency Services

* Therapy services provided at a licensed outpatient hospital facility are billed and prior authorized under other POS and TOS. Refer to the Medicaid hospital provider handbook (Part F) for more information.

Appendix 4
Wisconsin Medicaid Allowable HCPCS Procedure Codes and Copayments* for Physical Therapy Services
(For dates of service on and after September 1, 1995)

Deleted Codes	Procedure Codes	Description	Copayment	Daily Treatment Unit Limit	Procedure Codes Allowed by PTAs
Other Procedures					
97100 97200	93797	Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session) (15 minutes)	$1.00	1 per day	Not Allowed
97100 97200	93798	Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session) (15 minutes)	$2.00	1 per day	Not Allowed
97100 97200	94667	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation (30 minutes)	$1.00	1 per day	Allowed
97100 97200	94668	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; subsequent (30 minutes)	$1.00	1 per day	Allowed
97100 97200	94650	Intermittent positive pressure breathing (IPPB) treatment, air or oxygen, with or without nebulized medication; initial demonstration and/or evaluation (15 minutes)	$1.00	1 per day	Not Allowed
97100 97200	94651	Intermittent positive pressure breathing (IPPB) treatment, air or oxygen, with or without nebulized medication; subsequent (15 minutes)	$1.00	1 per day	Not Allowed
97100 97200	94652	Intermittent positive pressure breathing (IPPB) treatment, air or oxygen, with or without nebulized medication; newborn infants (15 minutes)	$1.00	1 per day	Not Allowed
Modalities					
97000 97200	97010	Application of a modality to one or more areas; hot or cold packs (15 minutes)	$1.00	1 per day	Allowed
97000 97200	97012	Application of a modality to one or more areas; traction, mechanical (15 minutes)	$1.00	1 per day	Allowed
97000 97200	97014	Application of a modality to one or more areas; electrical stimulation (unattended) (15 minutes)	$1.00	1 per day	Allowed
97000 97200	97016	Application of a modality to one or more areas; vasoneumatic devices (15 minutes)	$1.00	1 per day	Allowed
97000 97200	97018	Application of a modality to one or more areas; paraffin bath (15 minutes)	$1.00	1 per day	Allowed

* Therapy services provided at a licensed outpatient hospital facility are billed and prior authorized under other Medicaid procedure codes. Refer to the Medicaid hospital provider handbook (Part F) for more information.

Deleted Codes	Procedure Codes	Description	Copayment	Daily Treatment Unit Limit	Procedure Codes Allowed by PTAs
Modalities					
97000 97200	97020	Application of a modality to one or more areas; microwave (15 minutes)	$1.00	1 per day	Allowed
97000 97200	97022	Application of a modality to one or more areas; whirlpool (15 minutes)	$1.00	1 per day	Allowed
97000 97200	97024	Application of a modality to one or more areas; diathermy (15 minutes)	$1.00	1 per day	Allowed
97000 97200	97026	Application of a modality to one or more areas; infrared (15 minutes)	$1.00	1 per day	Allowed
97000 97200	97028	Application of a modality to one or more areas; ultraviolet (15 minutes)	$1.00	1 per day	Allowed
97000 97200	97032	Application of a modality to one or more areas; electrical stimulation (manual) (15 minutes)	$1.00	Not Applicable	Allowed
97000 97200	97033	Application of a modality to one or more areas; iontophoresis (15 minutes)	$1.00	Not Applicable	Allowed
97000 97200	97034	Application of a modality to one or more areas; contrast baths (15 minutes)	.50¢	Not Applicable	Allowed
97000 97200	97035	Application of a modality to one or more areas; ultrasound (15 minutes)	$1.00	Not Applicable	Allowed
97000 97200	97036	Application of a modality to one or more areas; Hubbard tank (15 minutes)	$1.00	Not Applicable	Allowed
97000 97200	97039	Unlisted modality (specify type and time if constant attendance) (15 minutes)	$1.00	1 per day	Allowed
97100 97200	90900	Biofeedback training; by electromyogram application (e.g., in tension headaches, muscle spasms) (30 minutes)	$3.00	1 per day	Allowed
Therapeutic Procedures					
97100 97200	97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility	$1.00	Not Applicable	Allowed
97100 97200	97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, proprioception	$1.00	Not Applicable	Allowed

Deleted Codes	Procedure Codes	Description	Copayment	Daily Treatment Unit Limit	Procedure Codes Allowed by PTAs
Therapeutic Procedures					
97100 97200	97113	Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises	$1.00	Not Applicable	Allowed
97100 97200	97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training	$1.00	Not Applicable	Allowed
97100 97200	97122	Therapeutic procedure, one or more areas, each 15 minutes; traction, manual	$1.00	Not Applicable	Allowed
97100 97200	97124	Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion)	$1.00	Not Applicable	Allowed
97100 97200	97139	Therapeutic procedure, one or more areas, each 15 minutes; unlisted therapeutic procedure (specify)	$1.00	Not Applicable	Allowed
97100 97200	97250	Myofascial/soft tissue mobilization, one or more regions (30 minutes)	$2.00	1 per day	Not Allowed
97100 97200	97265	Joint mobilization, one or more areas (peripheral or spinal) (15 minutes)	$2.00	1 per day	Not Allowed
97100 97200	97520	Prosthetic training; initial 30 minutes, each visit	$1.00	1 per day	Allowed
97100 97200	97521	Prosthetic training; each additional 15 minutes	$1.00	Not Applicable	Allowed
97100 97200	97530	Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance); each 15 minutes	$1.00	Not Applicable	Allowed
97100 97200	97540	Training in activities of daily living (self care skills and/or daily life management skills); initial 30 minutes, each visit	$2.00	1 per day	Allowed
97100 97200	97541	Training in activities of daily living (self care skills and/or daily life management skills); each additional 15 minutes	$1.00	Not Applicable	Allowed
Comprehensive Evaluation					
97700	Q0103	Physical therapy evaluation; initial (90 minutes)	$2.00	1 per day	Not Allowed
97700	Q0104	Physical therapy re-evaluation; periodic (30 minutes)	$1.00	1 per day	Not Allowed

Physical Therapy Procedure Codes *For dates of service before September 1, 1995*			
Procedure Code	**Modifier**	**Description**	**Copayment**
97000	n/a	Physical Therapy Treatment, single modality (30 minutes)	$1.00
97100	n/a	Physical Therapy Treatment, single procedure (30 minutes)	$1.00
97200	n/a	Physical Therapy Treatment, two or more or a combination of modalities, procedures, evaluations (30 minutes)	$1.00
97700	n/a	Evaluation (30 minutes)	$1.00
*W9542	n/a	Federally Required Annual Physical Therapy Evaluation	n/a
		* *Note:* When billing procedure code W9542, use diagnoses 317-319.	

Appendix 5
Conversion of Therapy Treatment Time to Wisconsin Medicaid Treatment Units for Billing Purposes*

The following charts illustrate the calculation of units of time for billing physical therapy services.

Conversion Chart for dates of service before September 1, 1995

For dates of service before September 1, 1995

Treatment Time (in minutes)	**Treatment Unit(s) Billed**
15	0.5
30	1.0
45	1.5
60	2.0
75	2.5
90	3.0

Conversion Charts for dates of service on and after September 1, 1995

CONVERSION TABLE 1
Treatment Time to Treatment Units for Procedure Codes
Referencing "15 Minutes of" in the Procedure Code Description
For dates of service on and after September 1, 1995

Actual Treatment Time (in minutes)	**Treatment Unit(s) Billed**
7.5	0.5
15.0	1.0
22.5	1.5
30.0	2.0
37.5	2.5
45.0	3.0

CONVERSION TABLE 2
Treatment Time to Treatment Units for Procedure Codes
Referencing "30 Minutes of" in the Procedure Code Description
For dates of service on and after September 1, 1995

Actual Treatment Time (in minutes)	**Treatment Unit(s) Billed**
15.0	0.5
30.0	1.0
45.0	1.5
60.0	2.0
75.0	2.5
90.0	3.0

* Therapy services provided at a licensed outpatient hospital facility use different Medicaid treatment units. Refer to the Medicaid provider handbook (Part F) for more information.

Conversion Charts for dates of service on and after September 1, 1995 (continued)

CONVERSION TABLE 3
Treatment Time to Treatment Units for Procedure Codes
Referencing "45 Minutes of" in the Procedure Code Description
For dates of service on and after September 1, 1995

Actual Treatment Time (in minutes)	**Treatment Unit(s) Billed**
15.0	0.3
22.5	0.5
30.0	0.6
45.0	1.0
60.0	1.3
67.5	1.5
75.0	1.6
90.0	2.0

CONVERSION TABLE 4
Treatment Time to Treatment Units for Procedure Codes
Referencing "90 Minutes of" in the Procedure Code Description
For dates of service on and after September 1, 1995

Actual Treatment Time (in minutes)	**Treatment Unit(s) Billed**
30.0	0.3
45.0	0.5
60.0	0.6
75.0	0.8
90.0	1.0

Appendix 6
List of Evaluations, Tests, and Measures

An evaluation (see Appendix 4) consists of one or more tests or measures used in assessing a recipient's needs. A written report of the evaluation results must accompany the test chart/form in the recipient's medical record.

Evaluations are counted toward the 35-day spell of illness prior authorization threshold.

The following list includes tests and measures which may be used in an evaluation.

- ✓ Stress test.
- ✓ Orthotic check-out.
- ✓ Prosthetic check-out.
- ✓ Functional evaluation.
- ✓ Manual muscle test.
- ✓ Isokinetic evaluation.
- ✓ Range of motion measure (goniometric).
- ✓ Length measurement.
- ✓ Electrical tests include the following:
  - → Nerve conduction velocity.
  - → Strength duration curve-chronaxie.
  - → Reaction of degeneration.
  - → Jolly test (twitch tetanus).
  - → "H" test.
- ✓ Respiratory assessment (spirometer, CO_2 exchange, chest expansion).
- ✓ Sensory evaluation.
- ✓ Cortical integration (evaluation).
- ✓ Reflex testing.
- ✓ Pain.
- ✓ Arthokinematic.
- ✓ Coordination evaluation.
- ✓ Posture analysis.
- ✓ Gait analysis.
- ✓ Crutch fitting.
- ✓ Cane fitting.
- ✓ Walker fitting.
- ✓ Splint fitting.
- ✓ Corrective shoe fitting (orthopedic shoe fitting).
- ✓ Brace fitting (assessment).
- ✓ Chronic-obstructive pulmonary disease evaluation.
- ✓ Hand evaluation.
- ✓ Skin temperature measurement.
- ✓ Oscillometric test.
- ✓ Doppler peripheral-vascular evaluation.
- ✓ Developmental evaluations include the following:
  - → Millani-Comparetti evaluation.
  - → Denver Developmental.
  - → Ayres.
  - → Gessell.
  - → Kephart and Roach.
  - → Bazelton Scale.
  - → Bailey Scale.
  - → Lincoln Osteretsky Motion Development Scale.
- ✓ Neuromuscular evaluation.
- ✓ Wheelchair fitting (evaluation, prescription, modification, adaptation).
- ✓ Jobst measurement.
- ✓ Jobst fitting (stockings).
- ✓ Perceptual evaluation.
- ✓ Pulse volume recording.
- ✓ Physical capacities testing.
- ✓ Home evaluation.
- ✓ Garment fitting.

Appendix 7
List of Modalities

A modality (see Appendix 4) consists of treatment involving physical therapy equipment or apparatus which does not require the physical therapist's personal continuous attendance during the periods of use but which does require setting up, frequent observations, and evaluation of the treated part prior to and after treatment. Treatments which are considered modalities include, but are not limited to, the following for payment purposes.

Hydrotherapy

✓ Hubbard tank (unsupervised).

✓ Whirlpool.

Electrotherapy

✓ Biofeedback.

✓ Electrical stimulation (transcutaneous nerve stimulation, medcolator).

Exercise Therapy

✓ Finger ladder.

✓ Overhead pulley.

✓ Restorator.

✓ Shoulder wheel.

✓ Stationary bicycle.

✓ Wall weights.

✓ Wand exercises.

✓ Static stretch.

✓ Elgin table.

✓ N-K table.

✓ Resisted exercise.

✓ PRE.

✓ Weighted exercise.

✓ Orthotron.

✓ Kinetron.

✓ Cybex.

✓ Skate (powder) board.

✓ Sling suspension modalities.

✓ Standing table.

Mechanical Apparatus

✓ Cervical and lumbar traction.

✓ Vasoneumatic pressure treatment.

Thermal Therapy

✓ Baker.

✓ Cryotherapy (ice immersion - cold packs).

✓ Diathermy.

✓ Hot pack - hydrocollator pack.

✓ Infra-red.

✓ Microwave.

✓ Moist air heat.

✓ Paraffin bath.

Appendix 8
List of Procedures

A procedure (see Appendix 4) consists of a treatment (with or without equipment or apparatus) which *does* require the physical therapist's personal continuous attendance. Treatments which are considered procedures for payment purposes include, but are not limited to, the following.

Hydrotherapy

✓ Contrast bath.

✓ Hubbard tank (supervised).

✓ Whirlpool (supervised).

✓ Walking tank.

Electrotherapy

✓ Biofeedback.

✓ Electrical stimulation (supervised).

✓ Electrogalvanic stimulation.

✓ Iontophoresis (ion transfer).

✓ Transcutaneous nerve stimulation (T.N.S.) (supervised).

✓ Hyperstimulation analgesia.

✓ Interferential current.

Exercise

✓ Peripheral vascular exercise (Beurger-Allen).

✓ Breathing exercises.

✓ Cardiac rehabilitation includes the following:
- → Immediate post-discharge from hospital.
- → Conditioning rehabilitation program.

✓ Codman's exercise.

✓ Coordination exercises.

✓ Exercise therapeutic (active, passive, active assistive, resistive).

✓ Frenkel's exercise.

✓ In-water exercises.

✓ Mat exercises.

✓ Neurodevelopmental exercise.

✓ Neuromuscular exercise.

✓ Postnatal exercises.

✓ Postural exercises.

✓ Prenatal exercises.

✓ Range of motion exercises.

✓ Relaxation exercises.

✓ Relaxation techniques.

✓ Thoracic outlet exercises.

✓ Stretching exercise.

✓ Preambulation exercises.

✓ Pulmonary rehabilitation program.

✓ Stall bar exercise.

✓ Back exercises.

✓ Phonophoreses.

Mechanical Apparatus

✓ Intermittent positive pressure breathing (IPPB).

✓ Tilt table (standing table).

✓ Ultrasonic nebulizer.

✓ Ultraviolet.

Procedures (continued)

Thermal

- ✓ Cryotherapy (ice massage) (supervised).
- ✓ Medcosonulator.
- ✓ Ultrasound.

Manual Application

- ✓ Accupressure (shiatsu).
- ✓ Adjustment of traction apparatus.
- ✓ Application of traction apparatus.
- ✓ Manual traction.
- ✓ Massage.
- ✓ Mobilization.
- ✓ Perceptual facilitation.
- ✓ Percussion (tapotement), vibration.
- ✓ Strapping (taping, bandaging).
- ✓ Stretching.
- ✓ Splinting.
- ✓ Casting.

Neuromuscular Techniques

- ✓ Balance training.
- ✓ Muscle reeducation.
- ✓ Neurodevelopmental techniques (PNF, Rood, Temple-Vay, Doman-Delacato, Cabot, Bobath).
- ✓ Perceptual training.
- ✓ Sensoristimulation.
- ✓ Facilitation techniques.

Ambulation Training

- ✓ Gait training (crutch, cane, walker).
- ✓ Gait training (level, incline, stair climbing).
- ✓ Gait training (parallel bars).

Miscellaneous

- ✓ Aseptic procedures (sterile).
- ✓ Functional training (activities of daily living) including:
  - → Self-care training.
  - → Transfers.
  - → Wheelchair independence.
- ✓ Orthotic training.
- ✓ Positioning.
- ✓ Posture training.
- ✓ Preprosthetic training includes the following:
  - → Desensitization.
  - → Strengthening.
  - → Wrapping.
- ✓ Prosthetic training.
- ✓ Postural drainage.
- ✓ Home program.

Appendix 9
Prior Authorization Request Form (PA/RF) for Physical Therapy Services Sample

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 111

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Im A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 55555

5 DATE OF BIRTH: MM/DD/YY

6 SEX: M ☐ F ☒

8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
I.M. Billing
1 W. Williams
Anytown, WI 55555

9 BILLING PROVIDER NO.: 87654300

10 DX: PRIMARY: 436 - CVA

11 DX: SECONDARY: 437.0 - Cerebral atherosclerosis

12 START DATE OF SOI: N/A

13 FIRST DATE RX: N/A

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 OR	20 CHARGES
97116	PT	4	1	Gait training/transferring 15 min x 3/wk x 11 wk	33	XXX.XX
97110	PT	4	1	Strengthening exercises 15 mins / 3 wk x 11 wk	33	XXX.XX
97032	PT	4	1	E Stim	20	XXX.XX
					TOTAL CHARGE	21 XXX.XX

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY
DATE

24 _____
REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐ APPROVED

GRANT DATE _____ EXPIRATION DATE _____ PROCEDURE(S) AUTHORIZED _____ QUANTITY AUTHORIZED _____

☐ MODIFIED — REASON:

☐ DENIED — REASON:

☐ RETURN — REASON:

_____ DATE

_____ CONSULTANT/ANALYST SIGNATURE

Appendix 9a
Prior Authorization Request Form (PA/RF) Completion Instructions (Physical Therapy)

See Appendix 10a of this handbook for Spell of Illness PA/RF instructions.

Element 1 - Processing Type
Enter processing type 111, Physical Therapy.

Element 2 - Recipient's Medicaid Identification Number
Enter the recipient's 10-digit identification number from the recipient's current identification card.

Element 3 - Recipient's Name
Enter the recipient's last name, first name, and middle initial from the recipient's current identification card.

Element 4 - Recipient's Address
Enter the address of the recipient's place of residence; the street, city, state, and zip code must be included. If the recipient is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 5 - Recipient's Date of Birth
Enter the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41) from the recipient's current identification card.

Element 6 - Recipient's Sex
Enter an "X" to specify male or female.

Element 7 - Billing Provider's Name, Address, and Zip Code
Enter the billing provider's name and complete address (street, city, state, and zip code). *Do not enter any other information in this element since it also serves as a return mailing label.*

Element 8 - Billing Provider's Telephone Number
Enter the billing provider's telephone number, including the area code, of the office, clinic, facility, or place of business.

Element 9 - Billing Provider's Medicaid Provider Number
Enter the billing provider's eight-digit provider number.

Element 10 - Recipient's Primary Diagnosis
Enter the appropriate *International Classification of Disease, 9th Edition, Clinical Modification* (ICD-9-CM) diagnosis *code and description most* relevant to the service/procedure requested.

Element 11 - Recipient's Secondary Diagnosis
Enter the appropriate ICD-9-CM diagnosis *code and description* additionally descriptive of the recipient's clinical condition.

Element 12 - Start Date of Spell of Illness
Do not complete this element *unless* requesting a therapy (PT, OT, speech) spell of illness. Enter the date of the first treatment for the spell of illness in MM/DD/YY format (e.g., March 1, 1988, would be 03/01/88).

Element 13 - First Date of Treatment
Do not complete this element *unless* requesting a therapy (PT,OT, speech) spell of illness. Enter the date of the first treatment for the spell of illness in MM/DD/YY format (e.g., March 1, 1988, would be 03/01/88).

Element 14 - Procedure Code(s)
Enter the appropriate HCPCS procedure code as described in the plan of care in this element.

Element 15 - Modifier
Enter the "PT" modifier appropriate for each procedure code.

Element 16 - Place of Service
Enter the appropriate place of service code designating where the requested service/procedure/item would be provided/performed/dispensed.

Code	Description
0	Other
3	Office
4	Home
7	Nursing Facility
8	Skilled Nursing Facility

Element 17 - Type of Service
Enter the appropriate type of service code for each service/procedure/item requested. *Do not complete* this element if requesting a therapy (physical therapy) spell of illness.

Numeric	Description
1	Medical
9	Rehabilitation Agency

Element 18 - Description of Service
Enter a written description corresponding to the appropriate HCPCS procedure code for each service/procedure requested.

Element 19 - Quantity of Service Requested
Enter the quantity (e.g., number of services, dollar amount) requested for each service/procedure requested.

Element 20 - Charges
Enter your usual and customary charge for each service/procedure requested. If the quantity is greater than "1," multiply the quantity by the charge for each service/procedure requested. Enter that total amount in this element.

> *Note:* The charges indicated on the *request form* must reflect the provider's usual and customary charge for the procedure requested. Providers are paid for authorized services according to the Department of Health and Family Services' *Terms of Reimbursement.*

Element 21 - Total Charge
Enter the anticipated total charge for this request.

Element 22 - Billing Claim Payment Clarification Statement
An approved authorization does not guarantee payment. Payment is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment is not be made for services initiated prior to approval or after authorization expiration. Payment is in accordance with Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid-contracted managed care program at the time a prior authorized service is provided, Medicaid payment is allowed only if the service is not covered by the managed care program.

Element 23 - Date
Enter the month, day, and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

Element 24 - Requesting Provider's Signature
The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

Do not enter any information below the signature of the requesting provider - This space is used by Medicaid consultant(s) and analyst(s).

Appendix 10
Prior Authorization Therapy Attachment (PA/TA) Sample
(Physical Therapy)

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/TA

THERAPY ATTACHMENT
(Physical- Occupational-Speech Therapy)

1. Complete this form
2. Attach to PA/RF
   (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

① LAST NAME	② FIRST NAME	③ MIDDLE INITIAL	④ MEDICAL ASSISTANCE ID NUMBER	⑤ AGE
Recipient	Im	A	1234567890	69

PROVIDER INFORMATION

⑥ THERAPIST'S NAME AND CREDENTIALS	⑦ THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER	⑧ THERAPIST'S TELEPHONE NUMBER
I.M. Performing	12345600	(XXX) XXX - XXXX

⑨ I.M. Referring/Prescribing
REFERRING/PRESCRIBING PHYSICIAN'S NAME

A. Requesting: ☒ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

B. Total time per day requested: 15 minutes
Total Sessions per week requested: 3
Total number of weeks requested: 11

C. Provide a description of the recipient's diagnosis and problems including date of onset.

R CVA

Hysterectomy 2° adenocarcinoma - 1992
Adult onset diabetes - several years duration
CHF - several years duration

D. Brief Pertinent History:

Patient was admitted 3/12/95 after hospitalization for acute CVA 2/27/95.

Hospitalized from 5/6/95 to 5/12/95 for pneumonia. Has been medically stable and alert since return on 5/12/95.

E. Therapy History:

	Location	Date	Problem Treated
PT	Hospital	3/1/95 to 3/11/95	CVA
	Nursing Home	3/13/95 to 5/6/95	CVA
		5/13/95 to present	

OT

N/A

SP

N/A

F. Evaluations: (Indicate Dates/Tests Used/Results) (Provide Date of Initial Evaluation)

	3/12/95	5/12/95
Orientation	A & O x 3	A & O x 3
ROM	WFL except L shldr flex= 0-140° Abd.= 0-140° Lat. Rot.= 0-45° L knee ext. = 10-100°	WFL except L shldr flex= 0-110° Abd.= 0-110° Lat. Rot.= 0-45° L knee ext.= 15°-95° L ankle dorsi flex= -10°
Strength	R extremities in GOOD range L UE flaccid L LE hip & knee POOR range	R U & L E F+ to GOOD- L UE non-func C moderate Flexor spasticity present L LE hip & knee FAIR L ankle TRACE
Transfers	Stnding pivot requires max of 2	Standing pivot mod of 1
Elevations	Supine ↔ sit max of 1 Sit ↔ stand max of 2	Supine ↔ sit min of 1 Sit ↔ stand mod of 1
Ambulation	Non-ambulation	In parallel bars of 10'x2 with max assist of 1, able to advance L LE indep. 70% of time
Sitting Balance	Unsupported requires max of 1	Unsupported indep. x 60 sec if unchallenged

G. Describe progress in measurable/functional terms since treatment was initiated or last authorized:

6/18/92

Orientation	0
ROM	L knee ROM= 5-100° L ankle dorsi flex= 0°
Strength	R UE & RLE - GOOD →G+ L UE-Zero, L LE - hip & knee - FAIR- ankle-POOR range, AFO obtained 5/15/95 to assist in transfer/gait.
Transfers	Standing pivot with guarded to min of 1 in PT & on unit
Elevations	Supine ↔ sit ↔ stand with guarded to min of 1.
Ambulation	10'x2 with minimum of 1 and hemi-walker. Amb. 1 x1/day on nursing unit.
Sitting Balance	Able to accept moderate challenges and maintain sitting balance.

H. Plan of Care (Indicate specific measurable goals and procedures to meet those goals).

	GOALS	PROCEDURES
1.	Amb. with cane With SBA of 1, 120'x2	Gait training Therapeutic exercise
2.	Indep. mobility, transfers	Therapeutic exercise
3.	Left knee ROM - Normal	Therapeutic exercise
4.	Left ankle strength POOR^{+} →FAIR	

Long Term Goals - Independent mobility, LLE ROM WNL, Return to semi-independent living

★ Code 97032 requested as possible adjunct, to therapeutic exercise.

I. Rehabilitation Potential:

Very good potential to meet goals. Patient has progressed steadily with short period of decline in May only.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

J.

Signature of Prescribing Physician (A copy of the Physician's order sheet is acceptable)	Signature of Therapist Providing Treatment
MM/DD/YY Date	MM/DD/YY Date

Appendix 10a
Prior Authorization Therapy Attachment (PA/TA) Completion Instructions (Physical Therapy)

Do not use this attachment to request a spell of illness. Use the Prior Authorization Spell of Illness Attachment (PA/SOIA).

Timely determination of prior authorization is significantly increased by submitting thorough documentation when requesting prior authorization to extend treatment beyond 35 treatment days for the same spell of illness. Carefully complete the Prior Authorization Therapy Attachment (PA/TA) form, attach it to the Prior Authorization Request Form (PA/RF), and submit to the following address:

EDS
Attn: Prior Authorization, Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Questions regarding the completion of the PA/RF and/or PA/TA may be directed to the fiscal agent's Policy/Billing Correspondence. Telephone numbers are in Appendix 2 of Part A, the all-provider handbook.

Recipient Information:

Element 1 - Recipient's Last Name
Enter the recipient's last name from the recipient's current identification card.

Element 2 - Recipient's First Name
Enter the recipient's first name from the recipient's current identification card.

Element 3 - Recipient's Middle Initial
Enter the recipient's middle initial from the recipient's current identification card.

Element 4 - Recipient's Medicaid Identification Number
Enter the recipient's ten-digit identification number from the recipient's current identification card.

Element 5 - Recipient's Numerical Age
Enter the age of the recipient in numerical form (e.g., 21, 45, 60, etc.).

Provider Information:

Element 6 - Therapist's Name and Credentials
Enter the name and credentials of the primary therapist who is responsible for and participating in therapy services for the recipient. If the performing provider is a therapy assistant, enter the name of the supervising therapist.

Element 7 - Therapist's Medicaid Provider Number
Enter the eight-digit provider number of the therapist who is providing the authorized service (performing provider). If the performing provider is a therapy assistant, enter the provider number of the supervising therapist. Rehabilitation agencies do not indicate a performing provider.

Element 8 - Therapist's Telephone Number
Enter the telephone number, including area code, of the therapist who is providing the authorized service (performing provider). If the performing provider is a therapy assistant, enter the telephone number of the supervising therapist.

Element 9 - Referring/Prescribing Physician's Name
Enter the name of the physician referring/prescribing evaluation/ treatment.

The remaining portion of this attachment is to be used to document the justification for the requested service.

1. Complete elements A through J.

2. Element E - Provide a brief past history based on available information.

   Element F - Provide the evaluation results (you may attach the therapy evaluation to comply with this requirement).

   Element I - Provide the recipient's perceived potential to meet therapy goals.

3. Read the 'Prior Authorization Statement' before signing and dating the attachment.

4. The attachment must be signed and dated by the primary therapist who is responsible for and participating in therapy services for the recipient. If the performing provider is a therapy assistant, the supervising therapist must sign the attachment.

   The request must be accompanied by a physician's signature (a copy of the physician's order sheet dated within 90 days of its receipt by the fiscal agent indicating the physician's signature is acceptable). Also, the request will be returned to the provider if the required documentation is missing from the request form.

5. Refer to Section III- E of this handbook for additional attachments that may be required.

Appendix 11
Prior Authorization Request Form (PA/RF)
Spell of Illness Sample
(Physical Therapy)

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 114

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Im A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 55555

5 DATE OF BIRTH: MM/DD/YY

6 SEX: M ☐ F ☒

8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
I.M. Billing
1 W. Williams
Anytown, WI 55555

8 BILLING PROVIDER NO.: 87654300

10 DX: PRIMARY: 436 - CVA

11 DX: SECONDARY: 437.0 - Cerebral atherosclerosis

12 START DATE OF SOI: MM/DD/YY

13 FIRST DATE RX: MM/DD/YY

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 OR	20 CHARGES
		8		Physical Therapy Spell of Illness	35	XX.XX
97116	PT	4	1	Gait Training		
97010	PT	4	1	Hot Packs		
				TOTAL CHARGE		21 XX.XX

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY (DATE) 24 _____ (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐ APPROVED — GRANT DATE _____ EXPIRATION DATE _____ PROCEDURE(S) AUTHORIZED _____ QUANTITY AUTHORIZED _____

☐ MODIFIED — REASON:

☐ DENIED — REASON:

☐ RETURN — REASON:

_____ DATE

_____ CONSULTANT/ANALYST SIGNATURE

Appendix 11a
Prior Authorization Request Form (PA/RF)
Spell of Illness Completion Instructions
(Physical Therapy)

Element 1 - Processing Type
Enter processing type 114, Physical Therapy (spell of illness only).

Element 2 - Recipient's Medicaid Identification Number
Enter the recipient's 10-digit identification number from the recipient's current identification card.

Element 3 - Recipient's Name
Enter the recipient's last name, followed by first name and middle initial, from the recipient's current identification card.

Element 4 - Recipient's Address
Enter the address of the recipient's place of residence; the street, city, state, and zip code must be included. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

Element 5 - Recipient's Date of Birth
Enter the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41) from the recipient's current identification card.

Element 6 - Recipient's Sex
Enter an "X" to specify male or female.

Element 7 - Billing Provider's Name, Address, and Zip Code
Enter the billing provider's name and complete address (street, city, state, and zip code). *Do not enter any other information in this element since it also serves as a return mailing label.*

Element 8 - Billing Provider's Telephone Number
Enter the *billing provider's* telephone number, including the area code, of the office, clinic, facility, or place of business.

Element 9 - Billing Provider's Medicaid Provider Number
Enter the billing provider's eight-digit provider number.

Element 10 - Recipient's Primary Diagnosis
Enter the appropriate ICD-9-CM diagnosis *code and description most* relevant to the service/procedure requested.

Element 11 - Recipient's Secondary Diagnosis
Enter the appropriate ICD-9-CM diagnosis *code and description* additionally descriptive of the recipient's clinical condition.

Element 12 - Start Date of Spell of Illness
Enter the date of onset for the spell of illness in MM/DD/YY format (e.g., March 1, 1988, would be 03/01/88).

Element 13 - First Date of Treatment
Enter the date of the first treatment for the spell of illness in MM/DD/YY format (e.g., March 1, 1988, would be 03/01/88).

Element 14 - Procedure Code(s)
Enter the procedure code as described in the plan of care.

Element 15 - Modifier
Enter the "PT" modifier appropriate for each procedure code.

Element 16 - Place of Service
Enter the appropriate place of service code.

Numeric	Description
0	Other
3	Office
4	Home
7	Nursing Home
8	Skilled Nursing Facility

Element 17 - Type of Service
Enter the appropriate type of service code for each service/procedure/item requested. This includes therapy services and therapy spells of illness (Physical Therapy).

Numeric	Description
1	Medical
9	Rehabilitation Agency

Element 18 - Description of Service
Enter the appropriate procedure code description.

Element 19 - Quantity of Service Requested
Enter the number of treatment days requested, per procedure code.

Element 20 - Charges (leave this element blank)

Element 21 - Total Charge (leave this element blank)

Element 22 - Billing Claim Payment Clarification Statement
Please read the "Billing Claim Payment Clarification Statement" printed on the request before dating and signing the prior authorization request form.

> "An approved authorization does not guarantee payment. Payment is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration. Payment is in accordance with Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid-contracted managed care program at the time a prior authorized service is provided, Medicaid payment is allowed only if the service is not covered by the managed care program."

Element 23 - Date
Enter the month, day, and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

Element 24 - Requesting Provider's Signature
The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

Do not enter any information below the signature of the requesting provider - This space is reserved for Medicaid consultant(s) and analyst(s).

Appendix 12
Prior Authorization Spell of Illness Attachment (PA/SOIA) Sample
(Physical Therapy)

Mail To:
E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/SOIA

PRIOR AUTHORIZATION SPELL OF ILLNESS ATTACHMENT
(Physical, Occupational, Speech Therapy)

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

① LAST NAME	② FIRST NAME	③ MIDDLE INITIAL	④ MEDICAL ASSISTANCE ID NUMBER	⑤ AGE
Recipient	Im	A.	1234567890	29

PROVIDER INFORMATION

⑥ THERAPIST'S NAME AND CREDENTIALS	⑦ THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER	⑧ THERAPIST'S TELEPHONE NUMBER
I.M. Performing PT	12345600	(XXX) XXX - XXXX

⑨ I.M. Referring MD
REFERRING/PRESCRIBING PHYSICIAN'S NAME

A. ☒ Physical Therapy SOI ☐ Occupational Therapy SOI ☐ Speech Therapy SOI

B. Provide a description of the recipient's diagnosis and problems. Indicate the functional regression which has occurred and the potential to reachieve the previous skill level.

PT fix'd pelvis on 6/18/94. Had been amb c cane c guarded to min assist of 1 on the unit. Was transferring c standby assist only. No % pain. Therapy initiated 6/25/94. PT requires max assist of 1 c walker to amb. Transfers require max of 1. % pain is constant c any movement. Expect PT to return to previous amb/transfer status and to be maintained by restorative nursing.

C. Attach a copy of the recipient's Therapy Plan of Care, including a current evaluation.

D. What is the anticipated end date of the spell of illness?

E. Supply the physician's dated signature on either the Therapy Plan of Care or the Physician's Order Sheet.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

F. _____ MM/DD/YY
Signature of Prescribing Physician (A copy of the Physician's Order Sheet is acceptable) — Date

G. _____ MM/DD/YY
Signature of Therapist Providing Evaluation/Treatment — Date

Appendix 12a
Prior Authorization Spell of Illness Attachment (PA/SOIA)
Completion Instructions
(Physical Therapy)

Do not use this attachment to request prior authorization to extend treatment beyond 35 treatment days for the same spell of illness. Use the Prior Authorization Therapy Attachment (PA/TA).

Timely determination of prior authorization is significantly increased by submitting thorough documentation when requesting prior authorization for a spell of illness. Carefully complete the Prior Authorization Spell of Illness Attachment (PA/SOIA) form, attach it to the Prior Authorization Request Form (PA/RF) and submit to the following address:

EDS
Attn: Prior Authorization, Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Questions regarding the completion of the PA/RF and/or PA/SOIA may be directed to the fiscal agent's Policy/Billing Correspondence Unit. Telephone numbers are in Appendix 2 of Part A, the all-provider handbook.

Recipient Information:

Element 1 - Recipient's Last Name
Enter the recipient's last name from the recipient's current identification card.

Element 2 - Recipient's First Name
Enter the recipient's first name from the recipient's current identification card.

Element 3 - Recipient's Middle Initial
Enter the recipient's middle initial from the recipient's current identification card.

Element 4 - Recipient's Medicaid Identification Number
Enter the recipient's 10-digit identification number from the recipient's current identification card.

Element 5 - Recipient's Age
Enter the age of the recipient in numerical form (e.g., 21, 45, 60, etc.).

Provider Information:

Element 6 - Therapist's Name and Credentials
Enter the name and credentials of the primary therapist who is responsible for and participating in therapy services for the recipient. If the performing provider is a therapy assistant, enter his/her name and credentials, also enter the name of the supervising therapist.

Element 7 - Therapist's Medicaid Provider Number
Enter the eight-digit provider number of the therapist who is providing the authorized service (performing provider). If the performing provider is a therapy assistant, enter his/her provider number and the provider number of the supervising therapist. Rehabilitation agencies do not indicate a performing provider.

Element 8 - Therapist's Telephone Number
Enter the telephone number, including area code, of the therapist who is providing the authorized service (performing provider). If the performing provider is a therapy assistant, enter his/her telephone number and the telephone number of the supervising therapist.

Element 9 - Referring/Prescribing Physician's Name

Enter the name of the physician referring/prescribing evaluation/treatment.

Part A

Enter an "X" in the appropriate box to indicate a physical, occupational, or speech therapy spell of illness request.

Part B

Enter a description of the recipient's diagnosis and problems. Indicate what functional regression has occurred and what the potential is to reachieve the previous skill.

Part C

Attach a copy of the recipient's Therapy Plan of Care, including a current dated evaluation, to the Spell of Illness attachment before submitting the spell of illness request.

Part D

Enter the anticipated end date of the spell of illness in the space provided.

Part E

Attach the physician's dated signature on either the Therapy Plan of Care or copy of the physician's order sheet to this attachment.

Read the 'Prior Authorization Statement' before signing and dating the attachment.

Part F

The signature of the prescribing physician and the date must appear in the space provided. (A signed copy of the physician's order sheet is acceptable.)

Part G

The dated signature of the therapist providing evaluation/treatment must appear in the space provided.

Appendix 13
Spell of Illness Guide

Injury/Illness	Submit PA/Spell of Illness Forms?	Treatment Days	Submit PA/TA Form?
First time in treatment (femoral fracture)	no	30 days	n/a
Second time in treatment (mild CVA-ability to reachieve ADLS is possible)	yes	65 days	Submit the PA/RF and PA/TA forms to the fiscal agent within two weeks before spell of illness ends.
Third time in treatment (decubitus ulcer)	This diagnosis never qualifies for a spell of illness.	100 days	Submit PA/RF and PA/TA forms to the fiscal agent within two weeks of evaluation.
Fourth time in treatment (humeral fracture)	yes	26 days	n/a
Fifth time in treatment (severe CVA-ability to reachieve ADLS is questionable)	Does not qualify as spell of illness	14 days	Submit PA/RF and PA/TA forms to the fiscal agent within two weeks of evaluation.

Appendix 14
Helpful Hints for Working with Wisconsin Medicaid

The following tips are a compilation of information collected from providers participating in the Wisconsin Occupational Therapy Association (WOTA) Medicaid Committee, and information presented at symposiums sponsored by the committee. The information has been edited and updated by the Bureau of Health Care Financing (BHCF) therapy consultants. These tips are meant as guidelines to improve your documentation and to assist you in completing Medicaid forms accurately and completely.

Prior Authorizations

✓ If information regarding the recipient's previous therapy history is unavailable, submit a prior authorization request.

✓ Fill out all forms completely and accurately. Each time a prior authorization request is sent back to the provider for more information, there is a delay in services.

✓ A prior authorization request must be sent to the fiscal agent at least two weeks, but no more than three weeks, before the expiration date of the existing prior authorization.

✓ Check the recipient's 10-digit identification number before mailing the request to the fiscal agent.

✓ Please list onset dates for all diagnoses. If specific dates are not available, enter an approximate date based on the best information available and explain the circumstances.

✓ Count weeks and sessions accurately to ensure authorizations for sufficient sessions. Count from the requested start date. Remember, the consultant cannot grant more than you request.

✓ The initial request for prior authorization can be backdated two weeks to the date the request is initially received by the fiscal agent. Continuous therapy may not be backdated. To request backdating, write "Please backdate to *(date)* because *(reason)*" on the PA/RF.

✓ In the event that your initial prior authorization request is returned for clarification, provide written clarification and attach your response to the original PA/RF and return this PA/RF with all attachments to the fiscal agent. The original PA/RF was stamped with the ICN date when it was first received by the fiscal agent. The prior authorization may be backdated to the ICN date, only if you specifically request this.

✓ In cases when you have difficulty getting a doctor's signature on the initial plan of care which has caused your prior authorization to be late, attach a memo of explanation which the fiscal agent may consider in dating your authorization.

✓ The codes at the bottom of the PA/RF near the consultant's signature are common messages regarding action or recommendations by the consultant which have been assigned a computer code.

✓ Remember to use black ink. This makes the photocopies easier to read.

✓ A plan of care must be formulated from a valid data base (evaluation). Prior authorizations are not approved if the evaluation results are not included.

✓ If there is an interruption in services and you have excess sessions to use, you may change frequency if appropriate for the recipient, as long as you don't exceed the number of sessions granted or the end date. Include an explanation of the circumstances on your next prior authorization.

Hints (continued)

- ✓ You may change your treatment plan during a prior authorization; however, be sure to include the dates and rationale on your next prior authorization request.
- ✓ Please write legibly, and ensure legibility of copies. If the consultant cannot read your documents, they may get sent back.
- ✓ Only use basic or common abbreviations.
- ✓ If your prior authorization is returned "denied," you have the right to call the consultant to discuss the decision. If the consultant agrees to change the decision, submit a new prior authorization request with the additional documentation required by consultant. Attach a copy of the denied prior authorization.
- ✓ If the consultant stands by the denial, the recipient has the right to appeal through the fair hearing process.
- ✓ Prior authorizations returned to the provider for more information must be returned to the fiscal agent within a two-week period.
- ✓ If the reviewing consultant writes "D/C at end of PA" on the returned PA/RF, and you feel the recipient would benefit from further treatment, write another prior authorization clarifying medical reason for additional treatment.
- ✓ Make sure your goals are objective, measurable, and functional.
- ✓ Record all progress, no matter how small.
- ✓ Include function and safety issues when appropriate.
- ✓ Try to use standardized evaluations whenever possible.
- ✓ Include norms with test scores.
- ✓ Include specific carryover recommendations for patient, facility, staff, and/or family. After six months, carryover must be demonstrated to grant continued treatment.
- ✓ Highlight pertinent data.
- ✓ Suggested formats:
  - → List your data in columns - past and present.
  - → Use areas, problems resolved, problems improved, problems unresolved, carryover.
- ✓ Maintenance is a covered treatment, as long as *skilled* therapy services are required.
- ✓ "Medical Necessity" is defined in HSS 101.03 (96m), Wis. Admin. Code.

Spells of Illness (SOIs)

- ✓ New diagnoses or exacerbations that result in a functional regression generally qualify as a spell of illness.
- ✓ Be sure to include a copy of the current evaluation, a comparison to prior abilities, and an estimate of the patient's ability to return to prior level of function.

Hints (continued)

- ✓ Remember, any health insurance (including Medicare) paid sessions (excluding inpatient hospital days) *count* toward the original 35 days of treatment for a spell of illness.

- ✓ You may submit a copy of the monthly signed doctor's orders in lieu of a signature on the PA/TA, as long as the order indicates what treatment the doctor is prescribing.

General Information

- ✓ BID treatment counts as one session, so long as it does not exceed 90 minutes per day.

- ✓ Daily treatment time must not exceed the limitation of 90 minutes per treatment day. However, under extraordinary circumstances you may request more time. After you receive payment for the 90 minutes, submit an adjustment form with the specific reason for exceeding the 90 minute limitation documented on the adjustment form.

- ✓ Make sure treatment and documentation by a PTA are in accordance with the Wisconsin Administrative Code laws and practice standards.

- ✓ Splinting treatment including evaluation and associated expenses are billed separately from other treatment sessions as durable medical equipment. Refer to the DME Index for correct procedure codes.

Appendix 15
Medicaid Declaration of Supervision for Non-Billing Providers

The following providers are issued non-billing provider numbers (*cannot be used independently* to bill Wisconsin Medicaid), must be under professional supervision to be Medicaid-certified providers, and *must* complete this form:

Alcohol and Other Drug Abuse Counselor (31/048)
Psychiatric Nurse (31/049)
Master's Level Psychotherapist (31/078)
Physical Therapy Assistant (34/077)
Occupational Therapy Assistant (35/114)
Speech Pathologist, BA Level (78/091)
Physician Assistant (88/079)

Return to: EDS, Attn: Provider Maintenance, 6406 Bridge Road, Madison, WI 53784-0006

Note: If supervisor and address change, refer to Appendices 34 and 34a of Part A, the all-provider handbook.

To be completed by the applicant who is a Non-Billing Provider or Current Non-Billing Provider who has a Change in Work Address or Supervisor (always required):

Name and Credentials:_____ Phone:(_____)_____

Work Mailing Address:_____

Since Medicaid payments cannot be made payable to me, I, _____, hereby direct the fiscal agent for Wisconsin Medicaid, EDS, to make checks payable to (clinic or supervisor's name for providers other than mental health) _____ for all claims payments for services performed by me under Wisconsin Medicaid. I understand that this payment arrangement shall continue in effect until the fiscal agent receives a new Declaration of Supervision form from me. When my supervisor, employer, or work address changes, I will immediately send this form completed again to the fiscal agent.

Date	Signature of Non-Billing Provider	Medicaid Provider Number
_____	_____	_____

To be completed by the Supervisor (always required):

Name:_____ Employer IRS #_____ Phone:(_____)_____

Address:_____

I, _____, am supervising the work of _____.
The effective starting date of my supervision was _____. I hereby acknowledge and agree to the above payment arrangement. I understand that if my name is indicated in the above section, Wisconsin Medicaid checks for services provided by the above provider will be payable to me directly and will be reported under the IRS# written here. If I discontinue supervision of the above, I understand that I must send notice to the fiscal agent at the above address.

Date	Signature of Supervisor	Medicaid Provider Number
_____	_____	_____

To be completed by the Clinic Manager (required for mental health non-billers only):

Note: Outpatient mental health/AODA clinics who employ non-billing providers *must* be certified by the Division of Community Services *and* Wisconsin Medicaid. Staff of non-51.42 board clinics providing Medicaid services *must* be individually certified.

On behalf of (Clinic Name) _____, (Medicaid Provider Number) _____
I hereby acknowledge and agree to the above payment arrangement. I understand that Wisconsin Medicaid checks for services provided by the above non-billing provider will be payable to the clinic and reported under this IRS#.

Date	Name and Signature of Clinic Manager	Employer IRS #
_____	_____	_____

Clinic Address:_____ Phone:(_____)_____

Appendix 16
Paperless Claim Request Form
Wisconsin Medicaid Electronic Information Request Form

Wisconsin Medicaid offers many different methods for submitting Medicaid claims electronically. All of this information is available for downloading from the EDS bulletin board system (EDS-EPIX). By downloading, you are able to obtain this information within minutes at your convenience. Please refer to the back of this page for the "Quick Guide to Obtaining Medicaid Electronic Claim Information" to assist you with the downloading process.

❑ **ECS (Electronic Claim Submission):** EDS supplies free software that runs on a stand-alone IBM compatible computer and uses a Hayes compatible modem. Electronic record layouts are also available to create your own data files containing Medicaid claim information.

❑ 3 1/2" diskette ❑ 5 1/4" diskette

❑ **3780 Protocol:** 3780 protocol is an IBM communication protocol that enables mini or mainframe computers to send claim data files to EDS.

❑ **Magnetic Tape:** Providers with the capability to create claim information on tape can submit those tapes to EDS. EDS also provides Remittance Advice information on magnetic tape.

❑ **MicroECS:** MicroECS allows providers to send data files to EDS using most basic telecommunication packages at a line speed up to 9600 bps.

❑ **Reformatter:** The Reformatter is software designed for EDS that enables providers to enjoy the benefits of electronic billing without making costly changes to their existing billing system. Instead of printing claims on paper, claims are printed to a data file on a personal computer and transmitted to EDS. EDS reformats the data into the required electronic record format and brings the claims into the Medicaid processing system.

❑ Please send me additional information on EDS' bulletin board system (EDS-EPIX).

If you are unable to download and would like information on electronic claim submission, please check off the above method(s) you are interested in and complete the following:

Name: _____ Provider Number: _____

Address: _____ Type of Service: _____

_____ Contact Person: _____

_____ Phone Number: _____

Please return to: EDS
6406 Bridge Rd.
Madison, WI 53784-0009

EDS-EPIX (V 1.1) Quick Guide to Obtaining Wisconsin Medicaid Electronic Information

This is a quick guide to retrieving and installing EDS' Electronic Claim Submission software using *EDS-EPIX.*

1. If you wish to obtain EDS Software, create a subdirectory on your hard drive for your Electronic Claim Submission software called "EDS". At the DOS command prompt, type:

   C: <Enter>
   CD\ <Enter>
   MD EDS <Enter>

2. Set up your communication software to dial *EDS-EPIX.* You may need to program your software to dial with the following settings:

Phone Number:	(608) 221-8824	**Stop Bits:**	1
Baud Rate:	14,400 (maximum)	**Duplex:**	Full
Parity:	None	**Protocol:**	XMODEM (recommended)
Data Bits:	8	**Terminal Emulation:**	ANSI

3. Dial into *EDS-EPIX.* When you go through this initial logon, we recommend you select Xmodem/CRC as your default protocol.

4. Select option "F" (File Directories) from the main menu, and view the "ECS Software and Manuals for New Users" or the "Record Layout and Manual Updates" directory. Choose the name of the file you need to download. If you need help deciding which file you need, go back to the main menu and view Bulletin #2 or 3 for more information. When you have chosen a file, write down the file name (you will need it to download).

5. Select option "D" (Download a File) from the main menu, and type the file name you chose in step 4. Next, follow the download instructions in the user manual for your communications software package. This involves telling your communications software package that you wish to "Receive a File", choosing a transfer protocol, and specifying the name and directory path of the file. If you fail to specify the directory path with the file name, the file will be downloaded into the default download directory for your communications software.

6. When you have downloaded your file, select "G" (Goodbye) to end your *EDS-EPIX* session, quit your communication software, and return to DOS.

7. Go to the subdirectory you specified in your path and look for your download file. It must be listed when you list the directory.

8. If the download file is in the directory, you will need to decompress the file. At the DOS command prompt, type the name of the download file without the ".EXE" extension. For example: for dental software, at the DOS command prompt, type:

   DENTAL <Enter>

9. This will extract your software and manual(s).

10. The files ending in .DOC are your manuals. This manual is an ASCII DOS text file. To print this document, use the DOS Print command:

    PRINT *FILENAME*.DOC <Enter>

    The document will be printed on the print device you specify.

Appendix 17
Avoiding and Resolving Common Claim Denials

EOB code	Message/Resource/Related Claim Form Element
281	Recipient Medicaid identification number incorrect Medicaid identification card or other eligibility resource → Part A, Section I-C Element 1a
29	Recipient's last name does not match number Medicaid identification card or other eligibility resource → Part A, Section I-C Element 2
614	Recipient's first name does not match number Medicaid identification card or other eligibility resource → Part A, Section I-C Element 2
278	Medicaid files show recipient has other health insurance Part A, Appendix 18 Element 9 (if paid also use element 29)
10	Recipient eligible for Medicare; bill Medicare first Part A, Appendix 17 Medicare-allowed charges → Attach Medicare EOMB Medicare Denied charges → Element 11 (use M-code and do not attach EOMB)
433	Physical therapy limited to 35 treatment days without prior authorization Part P, Section III Element 23
172	Recipient not eligible for date of service billed Medicaid identification card or other eligibility resource → Part A, Section I-C Element 24a
171	Claim/Adjustment received after 12 months from date of service Part A, Section 9-F Element 24a
177	Place of service invalid or not payable Part P, Appendix 4 Element 24b
180	Procedure not payable for type of service or invalid type of service code submitted Part P, Appendix 3 Element 24c
388	Procedure code is incorrect and/or the type of service is not correct for the procedure Part P, Appendix 3 Element 24c and/or 24d
183	Provider not authorized to perform procedure code and/or type of service code Element 24k
175	Performing Provider number is missing/invalid for this procedure Element 24k

EOB code	Message/Resource/Related Claim Form Element
424	Billing provider name/number missing, mismatched, or invalid Element 33
100	Claim previously/partially paid on (claim number and R & S date) Part A, Appendix 27 Adjustment Request Form
399	Date of service must fall between the prior authorization grant date and expiration date Part A, Section III-B

Note: ✓ HCFA 1500 claim form completion instructions are in Appendix 1b of this handbook.
✓ Request an amendment to authorized prior authorization grant and/or expiration dates to conform to the actual dates of service rendered.

Remittance and Status (R&S) Report with EOB Codes Example

This is a partial R&S Report. Actual R&S Reports contain more information. The EOB code is circled in this example.

REMITTANCE AND STATUS REPORT

EDS - Fiscal Agent For the Wisconsin Medical Assistance Program
6406 Bridge Road
Madison, WI. 53784
Voice Response 800/947-3544 608/221-4247
Policy/Billing 800/947-9627 608/221-9883
Eligibility 608/221-9254

PROVIDER NUMBER 87654321 REPORT SEQ NUMBER 2 DATE 07/06/92 PAGE 2

PATIENT NAME/ID NUMBER / SERVICE DATES FROM | TO	UNITS	PERF PROV ID NUMBER	MEDICAL RECORD NO / DAYS QTY	T OF S	PROC/ACCOM/DRUG CODE/MOD NO	ACCOUNTING NO / CLAIM NUMBER / PROCEDURE/ACCOMMODATION/DRUG DESCRIPTION	TOTAL BILLED	TOTAL ALLOWED	OTHER DEDUCTED CHARGES	COPAY	PAID AMOUNT	EOB CODES
ADJUSTMENT TO CLAIMS												
RECIPIENT IM/1234567890 112590 112590			2		1 90040	399892XXXXXXXXX BRIEF SERVICE	22 00	00	00	00	00	281 281 743 80
1 123 THIS IS AN ADJUSTMENT TO PREVIOUS CLAIM 209890XXXXXXXXX 1234567890						209890XXXXXXXXX	PAID ON 122690					
112590 112590			10		1 90040	CLAIM TOTAL	-2200 -2200	-1623 -1623	00 00	-100 -100	-1523 -1523	1 8
3 601 RECEIVABLE ESTABLISHED FOR A BALANCE OF $15.23 WHICH WILL BE WITHHELD FROM FUTURE PAYMENTS												
CLAIM TYPE SUB-TOTAL PAID CLAIM TOTALS			2 1				00 2200	1623 00	00 -104 28	000000 000000	-15 23 00	

Appendix 18
Blank HCFA 1500 Claim Form

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500